82-654

No.

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1982

ATLAS TILE & MARBLE COMPANY and
HARTFORD ACCIDENT & INDEMNITY COMPANY
Petitioners,

v.

JAMES R. SHAHADY

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION
PROGRAMS, U.S. DEPARTMENT OF LABOR,
Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

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QUESTIONS PRESENTED

1. Are the statutory and regulatory provisions of the Longshoremen's and Harbor Workers' Compensation Act, which require close supervision by the Director of the Office of Workers' Compensation Programs of medical treatment of injured workers, rendered inapplicable because a physician selected by the employer and insurance carrier renders an opinion that the worker is not in need of continuing medical treatment?

2. In such a circumstance, is the termination of active medical treatment by the physician to whom claimant is referred by the employer deemed to constitute a refusal or neglect by the employer to provide or authorize medical care or treatment under the Act?

LIST OF PARTIES

The parties to the case are set forth in the caption.

Petitioner is a subsidiary of International Telephone and Telegraph Corporation. Pursuant to Rule 28.1, Petitioner is affiliated with the following non-wholly owned subsidiaries:

Abbey International Corporation
Abbey Life Insurance Company of Canada
Abbey Overseas Group
Bonding and Insurance Agency & Insurance Factors, Limited
Cameron and Colby
First State Insurance Company
Four Thirty Seven Land Company, Inc.
Great Eastern Insurance Company
Hartex, Inc.
Hartford Accident and Indemnity Company
Hartford Casualty Insurance Company
Hartford Equity Sales Company, Inc.

Hartford Europe, Inc.
Hartfore Fire Insurance Company
Hartford Fund, Incorporated
Hartford Insurance Company of Alabama
Hartford Insurance Company of Illinois
Hartford Insurance Company of the Midwest
Hartford Insurance Company of the Southeast
Hartford Investment Services, Inc.
Hartford Life and Accident Insurance Company
Hartford Life and Annuity Insurance Company
Hartford Life Insurance Company
Hartford/Monitor Insurance Group
Hartford Real Estate Company
Hartford Securities Company, Inc.
Hartford Specialty Company
Hartford Variable Annuity Life Insurance Company
ITT Life Insurance Corporation
Lloyds Underwriters
London-Canada Insurance Company
Meridian 901 Corporation
New England Reinsurance Corporation
New York Underwriters Insurance Company
Nutmeg Insurance Company
One Hundred Edgewood Avenue, Inc.
Pacific Insurance Company, Limited
Prairie Lakes Investment Company
Sentinel Insurance Company, Ltd.
Terry Associates, Inc.
The Hartford Insurance Group Foundation, Incorporated
The Hartford Investment Management Company
Torrey Pines Bruno, Inc.
Tower Insurance Company of Connecticut
Translandno, Inc.
Twin City Fire Insurance Company
1810 Corporation

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v.

JAMES R. SHAHADY

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION
PROGRAMS, U.S. DEPARTMENT OF LABOR,
Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

Petitioners, Atlas Tile & Marble Company and Hartford Accident & Indemnity Company, pray that a Writ of Certiorari issue to review the order of the United States Court of Appeals for the District of Columbia Circuit entered in this proceeding on June 4, 1982.

OPINIONS BELOW

The opinion of the Court of Appeals was originally issued as a memorandum accompanying a judgment order entered on June 4, 1982 but was published at the request of the Respondent Director, Office of Workers' Compensation Programs and appears in the Appendix hereto (Appendix E, p. 7a), as do the opinion and decision of the Benefits Review Board dated June 11, 1981 (Appendix G, p. 25a), the separate opinion of Administrative Appeals Judge Miller, dissenting, dated September 21, 1981 (Appendix H, p. 38a) and the decision and order of Administrative Law Judge Robert A. Briggs, dated November 15, 1979 (Appendix I, p. 44a).

JURISDICTION

The Court of Appeals for the District of Columbia Circuit had jurisdiction under 33 U.S.C. § 921. The judgment of the Court of Appeals was entered on June 4, 1982 and petitioners motion for rehearing was denied on July 16, 1982. The petition for certiorari was filed within 90 days of the latter date. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(i).

STATUTES INVOLVED

United States Code, Title 33:

> § 907. Medical Services and Supplies.
>
> (a) The employer shall furnish such medical, surgical, and other attendance or treatment, nurse and hospital service, medicine, crutches, and apparatus, for such period as the nature of the injury or the process of recovery may require.

(b) The employee shall have the right to choose an attending physician authorized by the Secretary to provide medical care under this Act as hereinafter provided. If, due to the nature of the injury, the employee is unable to select his physician and the nature of the injury requires immediate medical treatment and care, the employer shall select a physician for him. The Secretary shall actively supervise the medical care rendered to injured employees, shall require periodic reports as to the medical care being rendered to injured employees, shall have authority to determine the necessity, character, and sufficiency of any medical aid furnished or to be furnished, and may, on his own initiative or at the request of the employer, order a change of physicians or hospitals when in his judgment such change is desirable or necessary in the interest of the employee. Change of physicians at the request of employees shall be permitted in accordance with regulations of the Secretary.

(c) The Secretary may designate the physicians who are authorized to render medical care under the Act. The names of physicians so designated in the community shall be made available to employees through posting or in such other form as the Secretary may prescribe.

(d) An employee shall not be entitled to recover any amount expended by him for medical or other treatment or services unless he shall have requested the employer to furnish such treatment or services, or to authorize provision of medical or surgical services by the physician selected by the employee, and the employer shall have refused or neglected to do so, or unless the nature of the injury required such treatment and

services and the employer or his superintendent or foreman having knowledge of such injury shall have neglected to provide or authorize the same; nor shall any claim for medical or surgical treatment be valid and enforceable, as against such employer, unless within ten days following the first treatment the physician giving such treatment furnish to the employer and the Secretary a report of such injury and treatment, on a form prescribed by the Secretary. The Secretary may, however, excuse the failure to furnish such report within ten days when he finds it to be in the interest of justice to do so, and he may upon application by a party in interest, make an award for the reasonable value of such medical or surgical treatment so obtained by the employee. If at any time the employee unreasonably refuses to submit to medical or surgical treatment, or to an examination by a physician selected by the employer, the Secretary may, by order, suspend the payment of further compensation during such time as such refusal continues, and no compensation shall be paid at any time during the period of such suspension, unless the circumstances justified the refusal.

(e) In the event that medical questions are raised in any case, the Secretary shall have the power to cause the employee to be examined by a physician employed or selected by the Secretary and to obtain from such physician a report containing his estimate of the employee's physical impairment and such other information as may be appropriate. Any party who is dissatisfied with such report may request a review or reexamination of the employee by one or more dif-

ferent physicians employed or selected by the Secretary. The Secretary shall order such review or reexamination unless he finds that it is clearly unwarranted. Such review or reexamination shall be completed within two weeks from the date ordered unless the Secretary finds that because of extraordinary circumstances a longer period is required. The Secretary shall have the power in his discretion to charge the cost of examination or review under this subsection to the employer, if he is a self-insurer, or to the insurance company which is carrying the risk, in appropriate cases, or to the special fund in section 44.

(f) An employee shall submit to a physical examination under subsection (e) at such place as the Secretary may require. The place, or places [sic] shall be designated by the Secretary and shall be reasonably convenient for the employee. No physician selected by the employer, carrier, or employee shall be present at or participate in any manner in such examination, nor shall conclusions of such physicians as to the nature or extent of impairment or the cause of impairment be available to the examining physician unless otherwise ordered, for good cause, by the Secretary. Such employer or carrier shall, upon request, be entitled to have the employee examined immediately thereafter and upon the same premises by a qualified physician or physicians in the presence of such physician as the employee may select, if any. Proceedings shall be suspended and no compensation shall be payable for any period during which the employee may refuse to submit to examination.

STATEMENT OF THE CASE

On November 19, 1975, claimant James R. Shahady while employed as a marble mason with the Atlas Tile & Marble Company, a petitioner herein, was injured when he jumped from an eighteen inch high platform, fell and landed on his left knee. About one week after the injury, claimant selected and came under the care of his family physician, Dr. Benjamin Pecson, a general practitioner. Because Dr. Pecson did not submit a medical report pursuant to 33 U.S.C. § 907(c), Hartford Accident & Indemnity Company, the insurance carrier and a petitioner herein, requested claimant to see Dr. Marvin Gibson, an orthopedist who first saw Mr. Shahady on October 8, 1976. Claimant voluntarily continued to see Dr. Gibson and ultimately left knee surgery was performed on April 2, 1977. Dr. Gibson provided follow-up treatment until April 14, 1978, when Dr. Gibson discharged claimant from continuing care, although he remained available for treatment as needed. Rather than returning, however, claimant again sought treatment from Dr. Pecson, and then ultimately changed physician to Drs. Gerald Schuster and Jacob Edelson for a further operation, and follow-up care. No consent was requested from the employer, carrier or deputy commissioner in accordance with § 7(d) of the Act, nor was written authorization for the change obtained. 33 U.S.C. § 907(b); 20 CFR § 702.406.

Claimant filed a claim for benefits under the Longshoremen's and Harbor Workers' Act, as amended, 33 U.S.C. § 901 *et seq.* (1976) as extended to cover employees under the District of Columbia Workers' Compensation Act, D.C. Code § 36-501 *et seq,* seeking payment for the medical expenses of Drs. Pecson, Schuster, and Edelson.

A formal hearing was held on October 19, 1979 before

an Administrative Law Judge who denied the claim for reimbursement for medical expenses based upon three separate grounds. First, the claimant had not requested that employer authorize treatment by Dr. Pecson, as provided in Section 7(d) of the Longshore Act. 33 U.S.C. § 907(d). Second, claimant had failed to obtain a prior written consent to change physicians from Dr. Pecson to Drs. Schuster and Edelson as required by § 7(b) of the Act and 20 C.F.R. § 702.406. Third, all three physicians had failed to submit timely medical reports pursuant to the terms of Section 7(d) of the Act.

On appeal, the Benefits Review Board, one member dissenting, agreed with the decision of the Administrative Law Judge that Claimant had failed to comply with the statutory requirements, and affirmed the denial of reimbursement for the medical expenses.

Claimant then filed a petition for review in the United States Court of Appeals for the District of Columbia Circuit pursuant to 33 U.S.C. § 921(c). The Director of the Office of Workers' Compensation Programs of the United States Department of Labor, who was not named as an agency respondent in claimant's petition, moved to amend and reform the caption to be included as a respondent (although aligning himself with the claimant/petitioner). The caption of the case was reformed in accordance with a decision of the United States Court of Appeals. *Shahady v. Atlas Tile & Marble Company,* 673 F.2d 479 (D.C. Cir. 1982). (Appendix F, p. 12a)

On June 4, 1982, the Court of Appeals reversed the Benefits Review Board and the Adminstrative Law Judge and held the employer and carrier responsible for the medical bills in question. The Court of Appeals held that although Dr. Gibson testified that he would have seen clai-

mant for as long as he wanted to come, his performance of a final examination and his discharge of claimant from continuing care was conduct which should be attributed to the employer and must be construed as refusal by the employer to provide medical care. The Court held claimant entitled to reimbursement for all necessary treatment subsequently procured on his own initiative. The Court of Appeals ignored claimant's failure to comply with the statutory and regulatory procedure for changing treating physicians. It further held that this constructive refusal to provide medical treatment, made it unncessary to address claimant's failure to request medical treatment in the first place under § 7(d) of the Act. The Court also held that the Administrative Law Judge abused his discretion in refusing to excuse the failure of Shahady's doctors to comply with the Act's requirements that a report be filed with the employer within ten days following the first treatment (33 U.S.C. § 907(d)) because the BRB's own precedent allegedly "makes clear" that a constructive refusal to provide medical care excuses the failure to file timely medical reports. (Appendix E, at p. 11a)

Petitioners filed a timely Petition for Rehearing with the Court of Appeals urging reconsideration in that the decision will have the widespread effect of nullifying the specific statutory requirement that the Deputy Commissioner of the Office of Workers' Compensation Programs actively supervise and monitor the medical management of compensation claimants, and will also effectively eradicate the medical reporting requirements set forth in the Act. On July 16, 1982, the petition for Rehearing was denied by the Court of Appeals without opinion. (Appendix C, p. 5a)

REASONS FOR GRANTING WRIT

I.

To Insure that the Expressed Congressional Intent Set Forth in the Longshoremen's and Harbor Workers' Compensation Act, that the Deputy Commissioner of the Office of Workers' Compensation Programs Actively Supervise and Monitor the Medical Management of Compensation Claimants, Not Be Effectively Repealed by Adoption of A Doctrine of Constructive Refusal to Provide Medical Care.

The opinion by the Court of Appeals has adopted a judicial doctrine which removes from the protection of the statutorily-mandated duty of the Deputy Commissioner of the Office of Workers' Compensation Programs to supervise and manage medical care of injured workers, those cases in which there exist differences in medical opinion, and which are therefore the cases in most need of the Deputy Commissioner's supervisory powers. This judicial abolition of the statutory safeguards is not only contrary to the expressed intent of Congress as found in § 7 of the Act, but it establishes a precedent which holds that if an independent physician, to whom a claimant has been referred by the employer or carrier[1] renders a medical opinion that a claimant is not in need of continuing medical treatment, because the physician believes either

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[1]The Court of Appeals termed such a physician "the employer's physician," a term which appears nowhere in the Act. The employer is not bound by such a physician's finding, and would be free, if given the opportunity, to reject his advice. In this case, the employer and carrier were never given the opportunity to take a position with respect to medical care.

that he has recovered, that he has no injury in the first place, that he would not benefit from further treatment,[2] or that some similar circumstance exists, then if the claimant disagrees, he need not even ask the employer, carrier or Deputy Commissioner for additional treatment or even inform any of them that he is seeking or obtaining treatment from new physicians. Aside from the obvious setbacks which could be dealt to an employee's recovery, and the prejudice to the employer and carrier, the result will be to deprive the Deputy Commissioner of the obligation to supervise the medical management of the injured worker. Indeed in a case such as this, where medical opinions may differ, it is the Deputy Commissioner who knows the local doctors, who can best ascertain if a change is warranted and who can determine what is in the claimant's best interest; yet that expertise and power is gone forever if the worker is given free reign to go anywhere he chooses – to a physician of the wrong specialty, to a doctor handpicked by his attorney, etc. This is particularly true where the physicians are not required to file medical reports to keep the Deputy Commissioner informed.

Congress' express intent that the Deputy Commissioner exercise close supervision is strewn throughout the statute and then reflected in numerous places in the Labor Department regulations. For example, § 7(b) of the Act delegates total control over medical treatment to the Secretary of Labor:

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[2]The very condition for which the Administrative Law Judge found later treatment necessary in this case was a condition which the physician to whom the carrier referred claimant *predicted* in his final report, and as to which he later testified was causally related, a condition of degenerative arthritis. The only difference of opinion was therefore one of medical judgment as to what treatment, if any, was appropriate at that time, not whether claimant had a continuing medical condition.

> The Secretary shall *actively supervise* the medical care rendered to injured employees, shall require periodic reports as to the medical care being rendered to injured employees, *shall have authority to determine the necessity, character, and sufficiency of any medical aid* furnished or to be furnished, and *may, on his own initiative or at the request of the employer, order a change of physicians* or hospitals when in his judgment such change is desirable or necessary in the interest of the employee. Change of physicians at the request of employees shall be permitted in accordance with regulations of the Secretary.

22 U.S.C. § 907(b) (emphasis added) This power has been assigned by the Secretary to the Director, O.W.C.P., and in turn to the Deputy Commissioners:

> § 702.407 Supervision of medical care
>
> The Director, O.W.C.P., through the deputy commissioners and their designees, *shall actively supervise the medical care* of an injured employee covered by the Act. Such supervision shall include:
>
> (a) The requirement that periodic reports on the medical care being rendered be filed in the Office of the deputy commissioner, the frequency thereof being determined by order of the deputy commissioner or sound judgment of the attending physician as the nature of the injury may dictate;
>
> (b) The determination of the necessity, character and sufficiency of any medical care furnished or to be furnished the employee;
>
> (c) The determination of whether a change of physicians, hospitals or other persons or locales

> providing treatment should be made or is necessary;
>
> (d) The further evaluation of medical questions arising in any case under the Act, with respect to the nature and extent of the covered injury, and the medical care required therefor.

20 CFR § 702.407. The primary purpose for these administrative powers is to benefit the employee – to protect him from unnecessary or questionable medical treatment. It also provides the employer and carrier with the ability to closely monitor their statutory rights and obligations and allows the Deputy Commissioner the ability to rid the system of abuses.

The Secretary's obligation to be kept current on all medical treatment is demonstrated by the statutory and regulatory ten-day reporting:

> . . . nor shall any claim for medical or surgical treatment be valid and enforceable, as against such employer, unless within ten days following the first treatment the physician giving such treatment furnish to the employer and the Secretary a report of such injury and treatment, on a form prescribed by the Secretary.

33 U.S.C. § 907(d). See also 20 CFR § 702.422.

The employer and carrier have a direct right to obtain medical examinations, and the employee may lose some of his compensation benefits for failure to comply:

> If at any time the employee unreasonably refuses to submit to medical or surgical treatment, or to an examination by a physician selected by the employer, the Secretary may, by order, suspend the payment of further compensation during such time as such refusal con-

> tinues, and no compensation shall be paid at any time during the period of such suspension, unless the circumstances justified the refusal.

33 U.S.C. § 907(d).

The Secretary is empowered by statute to conduct his own medical investigation, after which the employer and carrier have a statutory right to reexamination. 33 U.S.C. § 907(e). The regulations promulgated thereunder set forth specific procedures to be followed, particularly where medical issues are raised or medical opinions are disputed. 20 CFR § 702.408, 409.

Congress specifically empowered the employer to request the Secretary to change physicians, while leaving it to the Secretary to promulgate regulations pertaining to an employee's request to change physicians 33 U.S.C. § 907(b). The regulations promulgated by the Secretary permit a change of physician at the employee's request only where the employee has obtained the *prior written consent* of the employer, carrier or Deputy Commissioner. 20 CFR § 702.406.

Therefore, not only does the plain language of § 7(b) and (d) of the Act mandate a holding that a claimant must first request medical care from the employer in order to recover for medical expenses incurred and, thereafter, comply with reporting requirements and the procedure for change of physician, but the other statutory and regulatory provisions make it inconceivable that Congress intended to permit a claimant to recover for medical expenses which he sought on his own and as to which the Secretary, employer and carrier have had no opportunity to investigate or oversee.

The rationale behind Congress' requirement that an employee must first request authorization in order to ob-

tain payment for medical expenses is simple. The Act is set up not as a health insurance program whereby claims are presented for payment after the fact, but a program in which the Deputy Commissioner and insurance carrier play active and continuing roles in the ongoing medical treatment of a claimant. The requirement of a prior request for medical service has the dual effect of permitting the Deputy Commissioner to exercise its statutory duty to actively oversee medical care as well as to permit the carrier to assert its rights under the Act, with actual knowledge of a claimant's medical situation.

The Court of Appeals' opinion has negated both the statutory requirements and the detailed procedures set forth in the regulations in cases in which disputes arise concerning medical treatment. The Court's holding that Doctor Gibson's medical determination to discharge claimant from continuing active medical care equates to constructive refusal by the *employer* to provide medical care is tantamount to holding that the statutory and regulatory provision empowering the Deputy Commissioner to resolve medical disputes need never be brought into play because an employee may seek medical treatment on his own without complying with the statute whenever a dispute has arisen.[3]

---

[3]Again the Court of Appeals' designation of Dr. Gibson as "employer's physician" and its attribution to the employer of Dr. Gibson's conduct find no basis in the law of agency and ignores the independent nature of Dr. Gibson's practice. This is not a case arising prior to the 1972 amendments wherein an employee was bound to obtain treatment from a physician chosen by the employer, nor is Dr. Gibson a "house doctor." Rather, the claimant here could freely choose whether he wished to be treated by Dr. Gibson or by his initial free choice treating physician. There exists therefore no basis for the Court of Appeals' assertion that Dr. Gibson's medical judgment binds the employer and constitutes a constructive refusal of the employer to provide medical care.

The effect of the "constructive refusal" doctrine on other cases under this Act would likely be pervasive. In the majority of claims, medical treatment is routine and requires only limited monitoring by the Deputy Commissioner and carrier. In cases of complex or more unusual medical treatment, where there is often room for a legitimate difference of medical opinion, the employer and carrier have a statutory right to have a claimant examined by an independent physician of their choosing. 33 U.S.C. § 907(d). If that physician is in agreement with the course of treatment prescribed by the treating physician, then again the administrative monitoring need only be perfunctory. It is in cases in which the independent examining physician selected by the employer calls into question the nature, type or extent of treatment that the extensive administrative duties of the Deputy Commissioner are called directly into play and are of most importance. It is precisely this group of cases, which have the greatest need for active supervision by the Deputy Commissioner, in which the Court of Appeals' judicial legislation handcuffs the Deputy Commissioner's impartial invocation of the medical treatment provisions of the Act and eliminates the necessary supervision. Where a physician selected by the employer reports that there is no continuing disability from the injury, or that no additional medical treatment is needed, or where the physician himself does not undertake to perform treatment (for whatever reason), the decision below holds that a claimant need not comply with § 7(d) of the Act to request medical treatment at the outset, or with § 7(b) to request a change in physician thereafter, or to have any subsequent physician submit medical reports as required by § 7(d). 33 U.S.C. § 907(b) and (d). Where the question is one of proper medical management, as here, then under the Court of Appeals' analysis the issue would not be presented to the Deputy Commissioner as

statutorily required, but would be removed from the supervision of the Deputy Commissioner and be decided by claimant, his counsel and/or an unlimited number of future unknown physicians consulted only by claimant. For every individual who receives beneficial medical treatment on his own, many may fall prey to unscrupulous, unnecessary or repetitive medical treatment the Act was designed to guard against. The Deputy Commissioner's proper role represents the striking of a balance which preserves certain safeguards for employers and carriers under the Act, and protections designed into the Act for a claimant who may be particularly susceptible to unnecessary and overly aggressive medical care.

Because the factual situation of this case is not at all uncommon, the decision will have a widespread effect of nullifying the specific statutory requirement that the Deputy Commissioner of the Office of Worker's Compensation Programs actively supervise and monitor the medical management of compensation claimants. The choice between several potential courses of medical treatment should not be made on a retroactive basis once a course of treatment has been followed, but should be addressed by the Deputy Commissioner at a time in which the Deputy can act in the claimant's interest. An example of the effects of the opinion below is set forth in the recent Benefits Review Board case of *Lloyd v. Slattery Association, Inc.*, ____BRBS ____, BRB No. 80-515 (September 30, 1982) in which the Board apparently felt constrained to follow *Shahady* in the D. C. Circuit. Board member Kalaris in a concurring opinion convincingly explains that her concurrence is based upon her duty to follow the Court of Appeals in the D.C. Circuit despite her conviction that it is wrong. (Appendix J, p. 51a)

The decision below operates fundamentally to eliminate

the procedural requirements where a change of treating physicians is desired and will effectively eradicate the medical reporting requirements set forth in the Act. Because such a result is contrary to the intent of Congress is establishing the statutory scheme pertaining to medical care under the Act, and will have a potentially widespread negative impact on numerous other pending cases, this Court should review the decision of the U.S. Court of Appeals for the District of Columbia Circuit.

II.

To Settle an Important Question of Federal Law Which Has Not Been, But Should Be, Settled by This Court:

Does the opinion of a physician suggested by employer and voluntarily agreed to by a claimant, that the worker is not in need of continuing active medical treatment, constitute constructive refusal by the employer to furnish medical care under the statute where the employer never receives a request for medical care from the claimant and claimant never requests a change of physician under the procedure set forth in the Act?

The issue of whether a claimant's failure to comply with the Act's requirements for switching doctors for further medical care or the requirement to file medical reports should be excused under a newly created doctrine of constructive refusal to provide medical care is an important issue of federal law which has not been addressed by this Court. It should be noted that the Federal Respondent, Director, Office of Workers' Compensation Programs, has underscored the importance of the issues in this case initially by seeking party status while this case was on appeal and actively participating in briefing and arguing the involved issues. To again underscore the importance

with which the Director views this case, the Director requested the Court of Appeals to publish the decision which had originally been issued as an unpublished memorandum accompanying a judgment order. (Appendix A, p. 1a; Appendix E, p. 7a, footnote *)

Although the issues at stake have never been addressed by this Court, the Court of Appeals of several Circuits have stressed the importance of compliance with the terms of § 7 of the Act. In the case of *Maryland Shipbuilding & Dry Dock Company v. Jenkins,* 594 F.2d 404 (4th Cir. 1979), the Fourth Circuit reversed an award of medical expenses due to the claimant's failure to comply with § 7 of the Act. The Court focused on the importance of permitting the Secretary of Labor the opportunity to supervise medical care under the provisions of the Act. Although recognizing that the Act should be interpreted liberally, the *Jenkins* court held that "when claimant declined to request his employer to furnish additional medical services or to authorize such services, he failed to bring himself within the coverage of the Act." *Id.* at 406. The 4th Circuit also alluded to the failure of the physician to submit his report within ten days under the terms of § 7(d) and 20 CFR § 702.422, finding no evidence in the record sufficient to excuse the failure to file this report under regulation § 702.422(b). The Ninth Circuit has also denied recovery for medical expenses where a claimant failed to comply with the terms of the Act. *Nardella v. Campbell Machine,* 525 F.2d 45 (9th Cir. 1975). The *Nardella* Court specifically refused to disregard the plain terms of the Act under the guise of liberal interpretation. The *Jenkins* and *Nardella* holdings were entirely consistent with the holding of the Benefits Review Board below.

In a similar case, *Jackson v. Navy Exchange Service Center,* 9 BRBS 437 (1978), the Benefits Review Board also

denied reimbursement for medical expenses for failure to comply with § 7 of the Act. The Board found that the claimant's failure to request further medical treatment deprived the employer of the opportunity to respond and hence cannot be deemd and employer's refusal to provide medical care:

> Neglect only takes place after there is an opportunity to provide care. Before an employer could be said to have neglected to provide care, there must first have been a request for such care.

9 BRBS at 439.

The Court of Appeals in the instant case, however, cited none of the foregoing precedent, but rather purported to adopt the Fifth Circuit opinion in *Atlantic & Gulf Stevedores, Inc. v. Neuman,* 440 F.2d 908 (5th Cir. 1971). Its unexplained application of *Neuman* to this case should be reviewed and reversed for two separate reasons. Of supreme importance is that the opinion below adopted the *1971* Fifth Circuit case without discussion of the 1972 amendments to the Longshore Act which erected a far different statutory foundation upon which the medical expense issues must be determined. The amendments added specific provisions to the section pertaining to medical treatment to meet the concerns the Fifth Circuit expressed in *Neuman,* including giving a claimant the right to select an initial treating physician. Regulations authorized by the Act's amendments were promulgated in September, 1973, which set forth the appropriate procedures for selection and change of physicians. 33 U.S.C. § 939(a); 20 CFR § 702.401, *et seq.* In *Newman, supra,* the claimant was *limited to treatment from an employer selected physician* and he did *not* have the *opportunity* to request a change of physicians through the Deputy Commissioner. Because the

employer and the treating physician refused to provide medical care, the claimant had no choice but to seek treatment outside the provisions of the Act. The Fifth Circuit's opinion, under pre-amendment law, then articulated an equitable means by which claimant could be reimbursed for medical care since then he had no procedure to question the medical issues. The 1972 amendments, however, granted a claimant not only the right to select his own physician initially, but also, by establishing a procedure to change physician, filled the gap which had existed in *Neuman*. The *Neuman* rationale is therefore no longer applicable and the Court of Appeals' adoption of it without discussion of the effects of the 1972 amendment was grievous error.

Equally grievously, the opinion below substantially expanded the Fifth Circuit's holding and applied it to a significantly different factual situation. In *Neuman* the employer had *actively* resisted proposed medical treatment including successfully defending against *any* medical treatment at a formal hearing. When the claimant thereafter on his own initiative obtained a laminectomy, which proved the employer's litigation position erroneous, he was granted a modification of the prior award by the Deputy Commissioner. The adamant position taken by the employer in *Neuman* cannot colorably be compared to the facts in this case, where neither the claimant nor his attorney *ever asked the employer or carrier* to approve or disapprove additional care.

Here, under the Act's 1972 Amendments and the Labor Department regulations, the claimant had the inital right to select *his own* treating physician. Since he had that first free choice and had the further right to obtain a change of physician as appropriate by obtaining the prior written consent of the employer, the carrier or the Deputy Com-

missioner, he was protected from being arbitrarily locked into a physician selected by employer. It is undisputed in the present case that claimant had the opportunity to and did in fact select his own treating physician, Dr. Benjamin Pecson, to treat him for his work injury and the Administrative Law Judge so found. It is likewise undisputed that no contact was ever made with the employer, carrier or Deputy Commissioner by claimant or his attorney either to request medical treatment initially or to request a change in physician from his initial free selection at a later time.[4]

Because the 1972 amendments addressed the very concerns of the *Newman* court, and because the active refusal by the employer in *Neuman* differs substantially from this case, the Court of Appeals' decision below, adopting a doctrine of constructive refusal to provide medical care, will have the widespread effect of nullifying the statutory provisions designed to govern the medical treatment of injured workers under the Longshoremen's and Harbor Worker's Compensation Act. The Director, O.W.C.P., has below on several occasions stated that this issue is one of extreme importance. It is truly of substantial importance that this Court address the issues involved in this case and reinstate the plain statutory language.

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[4]Again, claimant had a freely chosen treating physician in this case, Dr. Pecson, but never sought authorization to change from *Dr. Pecson to Dr. Schuster,* the orthopedist who performed the ultimate surgery. The change of physicians had nothing to do with Dr. Gibson. This point was not discussed by the Court below.

III.

The Court of Appeals' Decision Below Has So Far Departed From the Accepted and Usual Course of Judicial Proceedings As To Call For an Exercise of This Court's Power of Supervision:

Even assuming that the actions of the employer-designated physician amounts to constructive refusal of the employer to furnish medical care under the statute, would such a constructive refusal eliminate the medical reporting requirements under Section 7(d) of the Act?

The Court of Appeals held that where a physician to whom a claimant has been referred by the employer has advised claimant that he is in need of no further treatment, no future physician consulted by claimant need ever report to the employer, carrier or Deputy Commissioner pertaining to ongoing treatment. This latter holding failed to discuss the consequences of unmonitored and unreported treatment or the policies giving rise to the statutory and regulatory provisions relating to reporting and monitoring medical treatment. Rather than addressing what the law should be in the District of Columbia Court, the Court of Appeals adopted this position simply by reference to the fact that the Benefits Review Board had previously discussed the issue and remanded the case for a discretionary determination of *whether* refusal to provide further medical care excused reporting. *Buckhaults v. Shipper's Stevedore Company,* 2 BRBS, 277, 280 (1975).

It is respectfully submitted that the Court of Appeals should have addressed these issues directly and determined whether or not an alleged constructive refusal to provide medical treatment should have any effect upon the Act's reporting requirements for later physicians rather than merely deferring to a prior decision of a lower judicial

body. If the Court determined that the rationale of *Buckhaults* was to be followed, it would be appropriate to set forth a detailed explanation of why constructive refusal would have any effect on medical reporting, particularly in light of the fact that such a decision represents a radical departure from the terms of the statute and regulations. This failure to confront the issue directly is even more egregious in light of the fact that such a holding would excuse the filing of reports *only* in cases in which disputes have arisen and which therefore present *a greater* need for close supervision. It is again the cases in which a dispute arises in which the Deputy Commissioner has the greatest need to be kept fully informed. To excuse the failure to report in such cases eradicates the only means which the Deputy Commissioner has to supervise treatment; yet discussion of these issues is absent from the Appeal Court's total deferral to *Buckhaults.*

Of perhaps more fundamental concern is the fact that the Benefits Review Board case to which the Court of Appeals totally defers does not even stand for the proposition for which it was cited. The Court of Appeals erroneously interpreted *Buckhaults* as holding that a constructive refusal to provide medical care constitutes an absolute defense to the failure to file later medical reports. In fact *Buckhaults* merely remanded the case for the Administrative Law Judge to address that issue and did not render a holding on it. This point was forcefully raised in the concurring opinion in *Lloyd v. Slattery Association Inc., supra,* set forth in the Appendix hereto, wherein Board member Kalaris felt constrained to reverse a denial of medical benefits based upon the Court of Appeals' decision in this case notwithstanding the Court of Appeals' erroneous interpretation of prior Board precedent. We now have a rule of law which the Board feels bound to follow,

yet *the rule of law has never been enacted as statute or held judicially in any proceeding.*

The Court of Appeals' adoption without discussion of a lower court opinion for a proposition for which the case does not even stand constitutes such a gross deviation from the usual and accepted course of judicial proceedings as to require this Court's exercise of supervision.

CONCLUSION

No prior decision of this Court has addressed the issues raised in this case. The Court of Appeals' opinion will have an enormous effect upon the administrative management of medical care under the Act. The Court of Appeals' reversal will obviously be deemed binding on the Benefits Review Board, and it will not only have to note the reversal, but will be required to adopt and cite the opinion in later cases in the D.C. Circuit, although presumably holding to its own view of the law in the other circuits. The Benefits Review Board has in fact already cited its *Shahady* opinion in later cases, which may now need to be retracted. *E.g. Betz v. Arthur Snowden Company,* 14 BRBS 805 (1981); *Shell v. Teledyne Mobile Offshore Inc.,* 14 BRBS 585 (1981).

Because the Court of Appeals' decision adopted *Neuman* and *Buckhaults* without appropriate analysis and failed to take into account either the effect of the 1972 amendments or the ramifications of its decision, this Court should grant certiorari and eliminate this unsettling and dangerous holding.

For the reasons set forth above, it is respectfully submitted that this Petition for a Writ of Certiorari should be granted.

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